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BEFORE THE
PHYSICAL THERAPY BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: DAVID GEORGE TURNER 2110 McLean Place Livermore, CA 94550 Physical Therapist License No. PT 18170 Respondent.	Case No. ID 2004 63882 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Steven K. Hartzell (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physical Therapy Board of California, Department of Consumer Affairs.

2. On or about April 21, 1992, the Physical Therapy Board of Califomia issued Physical Therapist License Number PT 18170 to DAVID GEORGE TURNER ("Respondent" or "Turner"). The Physical Therapist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2008, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Physical Therapy Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (hereinafter "the Code") unless otherwise indicated.

4. Section 2609 of the Code states:

"The board shall issue, suspend, and revoke licenses and approvals to practice physical therapy as provided in this chapter."

5. Section 2660 of the Code states:

"The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon, or issue subject to terms and conditions any license, certificate, or approval issued under this chapter for any of the following causes:

. . .

(h) Gross negligence in his or her practice as a physical therapist or physical therapy assistant.

(i) . . . violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the State Medical Practice Act.

(j) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(k) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(l) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapy assistant.

6. Section 2655 of the Code states:

"As used in this article:

(a) "Physical therapist" means a physical therapist licensed by the board.

(b) "Physical therapist assistant" means a person who meets the qualifications stated in Section 2655.3 and who is approved by the board to assist in the provision of physical therapy under the supervision of a physical therapist who shall be responsible for the extent, kind, and quality of the services provided by the physical therapist assistant.

(c) "Physical therapist assistant" and "physical therapy assistant" shall be deemed identical and interchangeable.

7. Section 2655.2 of the Code states:

"A physical therapist shall not supervise more physical therapist assistants at any one time than in the opinion of the board can be adequately supervised. Two physical therapist assistants shall be the maximum number of physical therapist assistants supervised by a physical therapist at any one time, but the board may permit the supervision of a greater number by a physical therapist if, in the opinion of the board, there would be adequate supervision and the public's health and safety would be served. In no case, however, shall the total number of physical therapist assistants exceed twice the number of physical therapists regularly employed by a facility at any one time."

8. Section 2655.7 of the Code states:

"Notwithstanding Section 2630, a physical therapist assistant may assist in the provision of physical therapy service provided the assistance is rendered under the supervision of a physical therapist licensed by the board."

9. Section 2655.92 of the Code states:

"The board may adopt regulations as reasonably necessary to carry out the purposes of this article. The board shall adopt a regulation formulating a definition of the term "adequate supervision" as used in this article."

10. Section 1398.44 of Title 16 of the California Code of Regulations states:

"1398.44. Adequate Supervision Defined.

"A licensed physical therapist shall at all times be responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient, provide direct care to the patient and to assure that the physical therapist assistant does not function autonomously. Adequate supervision shall include all of the following:

(a) The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients. The supervising physical therapist shall provide periodic on site supervision and observation of the assigned patient care rendered by the physical therapist assistant.

(b) The supervising physical therapist shall initially evaluate each patient and document in the patient record, along with his or her signature, the evaluation and when the patient is to be reevaluated.

(c) The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available to the supervising physical therapist. This information shall be communicated verbally, or in writing by the supervising physical therapist to the physical therapist assistant prior to initiation of treatment by the physical therapist assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapist assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education and training, of the physical therapist assistant.

(d) The supervising physical therapist shall reevaluate the patient as previously determined, or more often if necessary, and modify the treatment, goals and plan as needed. The reevaluation shall include treatment to the patient by the supervising physical therapist. The reevaluation shall be documented and signed

by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next reevaluation shall be performed.

(e) The physical therapist assistant shall document each treatment in the patient record, along with his or her signature. The physical therapist assistant shall document in the patient record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

(f) Within seven (7) days of the care being provided by the physical therapist assistant, the supervising physical therapist shall review, cosign and date all documentation by the physical therapist assistant or conduct a weekly case conference and document it in the patient record. Cosigning by the supervising physical therapist indicates that the supervising physical therapist has read the documentation, and unless the supervising physical therapist indicates otherwise, he or she is in agreement with the contents of the documentation.

(g) There shall be a regularly scheduled and documented case conference between the supervising physical therapist and physical therapist assistant regarding the patient. The frequency of the conferences is to be determined by the supervising physical therapist based on the needs of the patient, the supervisory needs of the physical therapist assistant and shall be at least every thirty calendar days.

(h) The supervising physical therapist shall establish a discharge plan. At the time of discharge, or within 7 (seven) days thereafter, a supervising physical therapist shall document in the patient's record, along with his or her signature, the patient's response to treatment in the form of a reevaluation or discharge summary."

11. Section 2630 of the Code states, in pertinent part:

"It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter.

12. Section 2661.5 (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case".

EVENTS

13. On or about April 29, 2004, the Physical Therapy Board received a complaint from Leslie Torburn (Torburn), a Physical Therapist (PT) and consultant for State Compensation Insurance Fund. Torburn alleged that after reviewing patient treatment notes from "PT Works" it appeared that the facility was not complying with regulations regarding appropriate supervision of Regie Abella (Abella), a Physical Therapist Assistant (PTA), by David Turner (Turner), the PT supervisor and manager of the clinic. The Division of Investigation ("DOI") thereafter conducted an investigation on behalf of the Board.

14. As part of the investigation, DOI investigators interviewed Torburn, who indicated as follows:

A. Torburn is a physical therapist consultant with State Compensation Insurance Fund (SCIF). Torburn has been a PT for several years. In March of 2002, Torburn evaluated the treatment notes for patient CH.[1]. While reviewing the notes, Torbum became concerned that PT Works was not following the PT regulations regarding appropriate supervision of a PTA.

B. Torburn contacted PT Works and spoke to "Maria," however

1. Full names of patients will be provided upon a proper Request For Discovery.

neither the practice administrator (later identified as Rebecca Coite), Abella, nor Turner was available. At this time, Torburn expressed her concern regarding appropriate PTA supervision. Torburn told Maria that she was recommending to the adjuster that "the patient [CH]" be referred to a different facility because the PTA is not receiving appropriate supervision. Torburn explained that without appropriate supervision from the PT, she could not be confident that patient CH was receiving the appropriate treatment interventions. Soon after, Coite called and spoke to Torburn regarding her concerns. Coite explained to Torburn that she was in the process of making changes to the office procedures and the forms used by staff at PT Works.

C. In late July of 2004, Torburn faxed Coite examples of redacted PT progress reports that, in Torburn's view were "well composed." Torbum provided the examples to Coite as a helpful guide for Coite to use while making the changes to PT Works forms. Torburn explained that Coite requested Torburn's assistance regarding "clear documentation."

15. On or about October 27, 2004, Marci Coronado, an investigator for the Division of Investigation, and Rita L. Arriaga, PT, (Arriaga) a consultant for the Physical Therapy Board, conducted an on-site facility visit and record inspection at PT Works located in Castro Valley. Present during the on-site inspection were Coite, the practice administrator, Janet Agnello (Agnello), the office manager, and Abella. Eugene Chen (Chen), a PT, and Jeannie Swart (Swart), a PTA, were also employees of PT Works, however, neither of these individuals was present. Turner was not present and his return date was unknown.

16. A total of 11 patients chart records were reviewed during the on-site facility visit and record inspection. The charts of five patients (CH, WJ (two separate charts), LP, CYW and LW) were specifically referenced in Torbums' complaint. WJ had two separate episodes of care that were documented in two separate charts. The mentioned patients received care at the PT Works between January 2002 and March 2004. Arriaga selected the following additional five patients' charts at random from the October 2004 PT Works appointment book: SH, TR, CHW, LS, and BL.

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17. Also evaluated during the on-site facility visit and record inspection were the current month (October, 2004) clinic appointment book as well as the appointment schedules for the months of January, 2002, August and December, 2003, and February, 2004. Arriaga also asked for and received copies of the clinic appointment schedule for the following: the weeks of January 14, 2002, July 28, 2003, December 29, 2003, February 16, 2004, October 4, 2004, and October 25, 2004. These weeks corresponded to some dates of PT services provided to patients whose charts were reviewed during the on-site inspection.

18. Also evaluated during the on-site facility visit and record inspection were billing statements (HCFA 1500's) for various dates of service for nine of the ten patients' treatment records.

19. Also evaluated during the on-site facility visit and record inspection were several forms currently used by the clinic: a billing form used by the PT staff to indicate the specific procedures or modalities to be billed for a given patient's visit, a clinic treatment authorization form, a PT progress report form, a PT evaluation form (initial and reassessment), the PT progress record/daily documentation form, a patient information sheet, and a medical history consent form to be completed by the patient.

20. The patient records that were reviewed at PT Works during the on-site facility visit and record inspection contained documentation of physical therapy treatments written by the following employed providers: Francisco Pelayo, PT (no longer employed by the clinic); Eugene Chen, PT; David Turner, PT; Regie Abella, PTA; and Jeannie Swart, PTA. Arriaga was advised by Rebecca and Janice (administrative support staff for the adjacent medical clinic) that there was a regular support staff person, "Lowell Alon" (Lowell), who usually worked every afternoon at the clinic, but Arriaga was unable to meet him. Lowell apparently provided front desk assistance for the physical therapy clinic and occasionally helped out as a physical therapy aide when needed.

21. The investigation including the on-site facility visit and record inspection revealed several violations and grounds for discipline under the Physical Therapy Practice Act (Business and Professions Code 2600 et seq.). The violations related generally to (1) the proper

utilization and supervision of PTA's, (2) adequate documentation of physical therapy services, (3) and appropriate billing for physical therapy services. More detail is as set forth hereinafter.

RE UTILIZATION AND SUPERVISION OF PTA'S

STANDARD OF CARE RE UTILIZATION AND SUPERVISION OF PTA'S

22. The physical therapist assistant (PTA) provides physical therapy only under the supervision of a physical therapist and only after a physical therapist has evaluated a patient and established the goals and treatment plan of care. The PTA can perform these services without the physical therapist being physically in the clinic; however, it is expected that the physical therapist will occasionally provide on-site supervision, will review the PTA documentation in patients' records, and will periodically provide some treatment to the patient. The community standard (and California regulatory requirement section 1398.44 of Title 16 of the California Code of Regulations) is weekly on-site supervision and record review, given the varying stages of rehabilitation for the patient population, and the requirement for the physical therapist's timely co-signature to indicate his/her agreement with what the PTA has documented in the patients' records. Periodic treatment by the physical therapist can range from once every few treatment sessions to only at the time of reevaluation depending upon the patient's needs or the complexity of the case. While the PTA can be expected to make decisions regarding patient progression per an identified plan of care, the physical therapist retains responsibility for reevaluating the patient and establishing the discharge plan. Thus, the physical therapist also has the responsibility to communicate the patient's progress to the referring physician which, in the outpatient environment, tends to coincide with reevaluations. This also provides the opportunity for a case conference between the physical therapist and the PTA regarding the patient to discuss any changes or modifications to goals and the plan of care. While the need for reevaluation and case conferencing varies based on individual patient progress and needs, the general standard is for at least monthly reassessments and/or meetings.

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ACTS OR OMISSIONS RE UTILIZATION AND SUPERVISION OF PTA'S

23. Respondent, as manager of PT Works and as supervising physical therapist, committed the following acts or omissions relating to his utilization and supervision of Physical Therapist Assistants:

A. Regarding the five patients listed in initial complaint (CH, WJ (two separate charts), LP, CYW and LW):

(1) Only 11 of the 90 treatment sessions provided to these 5 patients were provided by PT's. Three of the charts indicated that a physical therapist only treated the patient once (at the initial visit): CH's evaluation by F. Pelayo, WJ's (chart one) evaluation by E. Chen, and WJs' (chart 2) evaluation by D. Turner. All other treatments to these patients were provided by PTAs: R. Abella for all of CH's follow up treatments, all of WJ's (chart 1) follow up treatments, and the 1/14/04 follow up treatment for WJ (chart 2). J. Swart provided all other follow up treatments for WJ (chart 2)); and/or

(2) Only 14 of the 90 treatment session notes written by PTA's were co-signed by a physical therapist, all by D. Turner regardless of which PT did the initial evaluation; and/or

(3) None of the records contained documentation of any case conference between the PTA and the physical therapist; and/or

(4) Based upon PT Works appointment book, there was inadequate or no regular on-site supervision of any of the PTAs by a physical therapist. In fact, there were only two occasions in the appointment book records of the months reviewed where a PTA and a physical therapist were both physically present in the clinic at the same time (1/17/02 and 7/29/03); and/or

(5) One particular progress report for patient CH to the referring MD was written and signed by PTA R. Abella with no PT review or co-signature; and/or

(6) In all of the six charts of the five patients, the final treatment was documented by a PTA in all cases; there were no discharge summaries written by a PT.

B. Regarding the additional five patients' charts chosen at random from the October 2004 PT Works appointment book (SH, TR, CHW, LS, and BL):

(1) Only 19 of the 34 documented treatment sessions provided to these 5 patients were provided by PTA's (16 by R. Abella, and three by J. Swart). In these five charts, a physical therapist was shown as having provided treatments to the patients besides the initial visit; and/or

(2) Only nine of the 15 notes written-by PTA's were co-signed by a physical therapist (D. Turner); four of the remaining notes were still within the seven-day window for co-signature as of the date of the on-site visit; and/or

(3) None of the records contained documentation of any case conference between PTA and physical therapist. There was no record that they ever conferred. During the on-site visit, Abella was specifically asked if he ever met and discussed patient cases with either Turner or Chen. Abella's response was "no" but he knew how to reach them; and/or

(4) Based upon PT Works appointment book, there was inadequate or no regular on-site supervision of any of the PTAs by a physical therapist. The October, 2004, appointment book showed that there was no overlap of a PTA and physical therapist in the clinic; and/or

(5) The PT Works method of practice at the time of the on-site visit was that a physical therapist treated alone in the clinic on Tuesday and Thursday afternoons, primarily to perform initial evaluations and reevaluations, and a PTA (primarily Abella) treated alone in the clinic all other times.

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CAUSES FOR DISCIPLINARY ACTION
RE UTILIZATION AND SUPERVISION OF PTA'S

24. Respondent is subject to disciplinary action based upon the events, acts, or omissions, set forth hereinabove, pursuant to Business and Professions Code sections: 2660 (h); and/or 2660 (i); and/or 2660 (j); and/or 2660 (k); and/or for violating or attempting to violate, or assisting in or abetting the violating of, or aiding or abetting or conspiring to violate, section 1398.44 of Title 16 of the California Code of Regulations, including subdivision (a), and/or (b), and/or (c), and/or (d), and/or (f), and/or (g), in that:

A. As the manager and supervising licensed physical therapist, respondent did not properly supervise and/or ensure proper supervision all physical therapy services provided by the physical therapist assistant(s); and/or failed to ensure that the physical therapist assistant did not function autonomously [section 1398.44 of Title 16 of the California Code of Regulations]; and/or

B. As the manager and supervising physical therapist, respondent was not readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant was treating patients; and/or as the supervising physical therapist, respondent did provide periodic on site supervision and observation of the assigned patient care rendered by the physical therapist assistant [section 1398.44 (a) of Title 16 of the California Code of Regulations]; and/or

C. Respondent failed to document in the patient record, along with his signature, the evaluation and when the patient was to be reevaluated [section 1398.44 (b) of Title 16 of the California Code of Regulations]; and/or

D. Respondent, as the manager and supervising physical therapist, failed to communicate verbally, or in writing , to the physical therapist assistant, prior to initiation of treatment by the physical therapist assistant; and/or respondent, as the supervising physical therapist, failed to determine which elements of the treatment plan could be assigned to the physical therapist assistant, commensurate with the qualifications, including experience,

education and training, of the physical therapist assistant [section 1398.44 (c) of Title 16 of the California Code of Regulations]; and/or

E. Respondent, as a manager and supervising physical therapist, allowed the physical therapist assistant to perform Physical Therapy Progress Evaluations (and Reports), which can only be performed by a physical therapist [section 1398.44 (d) of Title 16 of the California Code of Regulations]; and/or

F. Respondent, as the manager and supervising physical therapist, failed to, within seven (7) days of the care being provided by the physical therapist assistant, review, cosign and date all documentation by the physical therapist assistant; and/or conduct a weekly case conference and document it in the patient record [section 1398.44 (f) of Title 16 of the California Code of Regulations]; and/or

G. Respondent, as the manager and supervising physical therapist, failed to conduct a regularly scheduled and documented case conference between the supervising physical therapist and physical therapist assistant regarding the patient [section 1398.44 (g) of Title 16 of the California Code of Regulations]; and/or

H. Respondent, as the manager and supervising physical therapist, allowed the physical therapist assistant to essentially practice independently and autonomously in the clinic with his own schedule and without the required co-signatures or documented patient conferences with respondent [section 2630 of the Code]; and/or

RE DOCUMENTATION OF PHYSICAL THERAPY SERVICES

STANDARD OF CARE RE DOCUMENTATION OF PHYSICAL THERAPY SERVICES

25. A physical therapist performs an evaluation when a patient initiates physical therapy and then conducts periodic reevaluations as needed. The evaluation consists of both a subjective examination (taking history of the chief complaint including medical history, symptoms including pain, aggravating and easing factors; reporting of functional limitations including ability to sleep, conduct ADL's, work, recreate or carry out social role) and an objective examination (measurements of joint flexibility and mobility, muscle strength, endurance, power, sensation, motor control, and movement patterns in gait and functional activities). The

expectation is that the physical therapist will document his/her specific findings from the subjective and objective examinations and will use these to develop (and document) individualized goals and plan of care to address the patient's problems. The standard of care is that documented goals are measurable and that the plan of care specifies the therapeutic procedures and/or modalities that need to be utilized to achieve the goals and the frequency and expected duration of the physical program. Specific treatment parameters are expected to be documented at least once within the record for reference by treating providers (e.g., specific exercise routines or progressions, specific dosages for modality application.). Each subsequent treatment session following the initial evaluation is expected to be documented by the provider of care (physical therapist, PTA) in the patient's medical record. The professional standard is that the record of these sessions should at a minimum include the date of service, what services (procedures/modalities) were provided, and the signature of the provider (with appropriate co-signature as required). Patient response to treatment in the form of changes in the patient's subjective or objective status from the initial findings should be documented as they occur by the treating physical therapist or PTA. A periodic formalized reevaluation in which most if not all deficits in subjective and objective findings are re-measured is conducted by the physical therapist. In the outpatient setting this often occurs in tandem with progress reports to referring physicians that may or may not also accompany requests to payers for authorization or reauthorization of physical therapy treatment. The timing for these reevaluations can vary, but usually occur at least monthly. At some point in the course of treatment (sometimes at the initial visit) the physical therapist is expected to document plans for patient education as well as discharge. The final note in the chart should include an indication of patient discharge and disposition. Licensed physical therapists, whether as manager, employer, or employee, are individually responsible to meet professional documentation standards for patients they treat. The PT manager of a clinic bears additional responsibility to assure that his/her employees meet practice standards in the documentation of physical therapy services.

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ACTS OR OMISSIONS RE DOCUMENTATION OF PHYSICAL THERAPY SERVICES

26. Respondent, as manager of PT Works and as supervising physical therapist, committed the following acts or omissions relating to his documentation of physical therapy services:

A. Regarding the five patients listed in initial complaint (CH, WJ (two separate charts), LP, CYW and LW):

(1) None of the initial evaluations met the standard of care or regulatory requirements: and/or

(2) One evaluation (patient LP) contained no subjective or objective exam (signed by Chen); and/or

(3) Two of the initial evaluations (patients CYW and LW) contained inadequate objective information (both signed by Chen); and/or

(4) All goals set forth in the initial evaluations were inadequately vague, and none were measurable; and/or

(5) One goal set forth in the initial evaluation had preprinted goals on the form that were not individualized to the patient (signed by Pelayo); and/or

(6) No plan was found in 3 charts (patients LP, CYW and LW). (All evaluated by Chen); and/or

(7) One plan was pre-printed (patient CH) (evaluated by Pelayo); and/or

(8) Two plans were inadequately vague (patients CH and WJ); and/or

(9) There were no parameters documented for any of the procedures or modalities utilized in treatment; and/or

(10) There was a list of procedures and modalities written at the top of each page; however, it was unclear that all were provided at each treatment session documented on the page; and/or

(11) While each note contained at least subjective information re patient response to treatment, there was inadequate objective information documented by any of the physical therapists; and/or

(12) The reevaluations were inadequate or non-existent. There was only one reevaluation (patient LP reevaluated by Turner) documented (2/19/04) in the record. The reevaluation was inadequately sparse although it was accompanied by a report to the referring MD. No other charts contained a reevaluation despite treatment programs that spanned six weeks to over two months: and/or

(13) The discharge notations were non-existent. None of the charts contained a discharge note or discharge summary.

B. Regarding the additional five patients' charts chosen at random from the October 2004 PT Works appointment book (SH, TR, CHW, LS, and BL):

(1) None of the initial evaluations met the standard of care or regulatory requirements: and/or

(2) Four initial evaluations (all by Turner) were on a new form but contained inadequate subjective and objective information; and/or

(3) One initial evaluation (patient LS signed by Chen) was on the older form and contained inadequate subjective and objective information; and/or

(4) One initial evaluation (patient LS) has no goals, while the remaining four charts contained vague, unmeasurable goals ; and/or

(5) With respect to a documented plan, two of the charts only state 'per MD', which was inadequate; and/or

(6) One chart (patient LS) has no documented plan; and/or

(7) The remaining two charts had vague, incomplete documented plans: and/or

(8) There were no parameters documented for any of the procedures or modalities utilized in treatment; and/or

(9) There was a list of procedures and modalities written at the top of each page; however, it was unclear which procedures and modalities were provided at each treatment session documented on the page; and/or

(10) While each note contained at least subjective information re patient response to treatment, there was inadequate objective information documented by any of the physical therapists; and/or

(11) The reevaluations were inadequate or non-existent. There was only one chart in which a reevaluation was applicable (Patient SH); there was a note (signed by Turner) that stated that a reevaluation was performed on a specific date, but there was no accompanying documentation to support it.

CAUSES FOR DISCIPLINARY ACTION
RE DOCUMENTATION OF PHYSICAL THERAPY SERVICES

27. Respondent, as manager and supervising physical therapist, is subject to disciplinary action based upon the events, acts, or omissions, set forth hereinabove, re documentation of physical therapy services, pursuant to Business and Professions Code sections: 2660 (h); and/or 2660 (i); and/or 2660 (j); and/or 2660 (k).

RE APPROPRIATE BILLING FOR PHYSICAL THERAPY SERVICES

STANDARD OF CARE RE APPROPRIATE BILLING FOR PHYSICAL THERAPY SERVICES

28. The physical therapist uses billing codes (CPT) to describe to payers what procedures they have performed for patients to receive reimbursement for physical therapy services. The standard of practice was that the physical therapist's documentation in the patient's medical records supports the specific billing codes submitted to the payer. That is, for a particular date of service on a billing claim (the HCFA 1500) there is corresponding documentation to be found in the patient's physical therapy record that the particular procedures and/or modalities (e.g., therapeutic exercise and ultrasound) were delivered to the patient on that date by an appropriately licensed and/or supervised physical therapy provider. The documentation will not only provide evidence to support the type of procedures and/or modalities billed but it will also

provide support for the complexity or length of time spent performing the services when such variables can be applied to a claim to gain added reimbursement. For example, certain billing codes can be utilized to indicate that more time was spent to perform a procedure (e.g., 45 minutes instead of 30) or to signal the payer that the procedure required more effort on the part of the provider due to the complexity (e.g. multiple diagnoses) of the particular case. Workers Compensation in particular provides several new and established patient evaluation billing codes to allow the physical therapist choices to best describe the effort utilized to evaluate (or reevaluate) a patient. The expectation is that documentation in the patient's medical record will support the therapist's claim (of more time or complexity) for additional remuneration. The licensed physical therapist bears a responsibility to assure that billing claims accurately reflect the type and level of service he/she (or his/her support staff) provides to the patient. A licensed PT and PT manager of a clinic bears the responsibility to assure that claims submitted to payers accurately reflect the level and type of services provided by the physical therapy staff. He or she also has the responsibility to assure that the staff submits billing information that is supported by their documentation in the patients' records.

ACTS OR OMISSIONS RE APPROPRIATE BILLING FOR PHYSICAL THERAPY SERVICES

29. Respondent, as manager of PT Works and as supervising physical therapist, committed the following acts or omissions relating to appropriate billing for physical therapy services:

A. Regarding the five patients listed in initial complaint (CH, WJ (two separate charts), LP, CYW and LW):

(1) All charts reviewed were for claims submitted to State Compensation Insurance Fund. The physical therapy documentation did not support the level of the evaluation and reevaluation billing codes to the payer; and/or

(2) For patient WJ (12/30/03 start of care, evaluation performed by Turner), the HCFA 1500 claim showed a bill submitted for a comprehensive evaluation, new patient, performed on 12/30/03 (billed CPT 98774). The documented physical

therapy evaluation did not support this level of complexity: and/or

(3) Two reevaluation HCTA claims were submitted for a comprehensive evaluation, established patient (98778), performed on 2/19/04 by Turner for patient LP and on 2/10/04 by Turner for LW. The documentation in each of these two charts did not provide evidence that this level of complexity/comprehensiveness was required or performed on the billed dates of service. On any given date of service, there was no documentation of specific procedures or modalities or parameters of their use. The listing of services at the top of each page did not meet professional standards for documentation; and/or

(4) For patient CH (date of service (DOS) 2/20/02), there was no co-signature of the PTA documentation of that treatment (performed by Abella), therefore appropriately supervised physical therapy treatment cannot be claimed. The documentation did not support the codes submitted on the HCFA 1500 form: and/or

(5) For patient LP (DOS 2/19/04), the documentation submitted for HCFA claim 98778, 97014, 97110 and 97250 (by Turner) for that DOS not only did not support the comprehensive reevaluation, it also did not specifically reference procedures or modalities listed elsewhere on the page and the note was unsigned: and/or

(6) For patient CYW (DOS 2/10/04) (HCFA claim submitted for 98778 + 97014, 97110 and 97250), there was no reevaluation documentation nor was there reference on that DOS to specific modalities or procedures listed elsewhere on the page to support the claim that these procedures/modalities were provided to the patient (treatment documentation by Turner); and/or

(7) For patient LW (DOS 2/13/04), the documentation (by Abella) did not reference specific procedures/modalities listed elsewhere on the page so provided no support that the procedures/modalities on the HCFA claim of 97014, 97110 and 97250) were provided to the patient on this date. The DOS of 2/17/04 documentation did not support use of the 97014 code that appears on HCFA claim; and/or

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(8) The very same billing codes (97014, 97110, 97250) were used repeatedly on the HCFA claims for all of these patients despite varying diagnoses carpal tunnel syndrome, neck/shoulder strain, back strain).

B. Regarding the additional five patients' charts chosen at random from the October 2004 PT Works appointment book (SH, TR, CHW, LS, and BL):

(1) Each of the five patients had different payers: Constitution State Services, Blue Cross, Intercore, Republican Indemnity, and Travelers; and/or

(2) The physical therapy documentation did not support the level of the evaluation billing code that was billed for patient LS on 10/19/04 (98774). The evaluation (performed by Chen) contained only minimal information about the patient's subjective or objective status and contains no goals or appropriate plan of care; and/or

(3) For the HCFA claims form for the initial dates of service for each of the other patients, a 98774 was billed; however, none of the charts contained initial evaluation documentation to support the use of the comprehensive evaluation code; and/or

(4) The current billing form utilized by the physical therapist or PTA to submit 'billing' information to the billing staff provided only one workers compensation evaluation and reevaluation code choice to the PT (98774 and 98778) thus preventing therapists from indicating any gradations to this 'norm'; the clinic had a policy of billing all physical therapy initial evaluation and reevaluations as 'comprehensive' for all patients. The physical therapists failed to assure that their evaluation/reevaluation documentation justified the use of these codes or to ask that a different billing code be used that more accurately reflects the lesser effort; and/or

(5) There continued to be no documentation of the specific treatment parameters for procedures and/or modalities utilized to provide care; and/or

(6) For patient LS (DOS 10/19/04), the documentation (by Chen) did not support the initial evaluation level that was billed on the HCFA claim (98774); and the documentation also did not support the additional procedure codes that also appeared on

the HCFA claim for that DOS (97250, 97110, 97014, 97010); the documentation for that DOS made no reference to these procedures/modalities having been provided to the patient; and/or.

(7) The very same billing codes (97014, 97110, 97250) appeared on all the HCFA claims submitted to payers for these five patients; the same three codes were being billed as with the original patients but with the addition of a fourth code, 97010.

CAUSES FOR DISCIPLINARY ACTION
RE APPROPRIATE BILLING FOR PHYSICAL THERAPY SERVICES

30. Respondent, as manager and supervising physical therapist, is subject to disciplinary action based upon the events, acts, or omissions, set forth hereinabove, re appropriate billing for physical therapy services, pursuant to Business and Professions Code sections: 2660 (h); and/or 2660 (i); and/or 2660 (j); and/or 2660 (k).

ADDITIONAL CAUSES FOR DISCIPLINARY ACTION

31. Respondent, as manager and supervising physical therapist, had primary responsibility to ensure that physical therapy services were provided in a manner that met the standard of practice and conformed with applicable statutory and regulatory requirements. Respondent repeatedly failed to ensure that the standard of practice and applicable statutory and regulatory requirements were being met in the three categories set forth hereinabove, to wit, (1) appropriate utilization and supervision of PT assistants; (2) documentation of physical therapy services provided to patients including the initial evaluation/reevaluation, progress records and reports, and discharge summary; and (3) accurate, honest submission of insurance claims that reflect the kind and type of services provided and that were supported by the documentation in the medical record. Respondent is therefore subject to disciplinary action based upon his combined acts or omissions, in part or in whole, as alleged in the three categories set forth hereinabove, pursuant to Business and Professions Code sections: 2660 (h); and/or 2660 (i); and/or 2660 (j); and/or 2660 (k).

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physical Therapy Board of California issue a decision:

1. Revoking or suspending Physical Therapist License Number PT 18170, issued to DAVID GEORGE TURNER;

2. Ordering DAVID GEORGE TURNER to pay the Physical Therapy Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2661.5;

3. Taking such other and further action as deemed necessary and proper.

DATED: December 5, 2006

Original Signed By:
STEVEN K. HARTZELL
Executive Officer
Physical Therapy Board of California
Department of Consumer Affairs
State of California
Complainant